# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7423

## CERTIFICATE OF DEATH

07359

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 10mos. 2weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 307 Vista St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: George — Middle: Sam — Last: Badrich

4. **DATE OF DEATH**: Month: June — Day: 26 — Year: 1960

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 6, 1890

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith & Maintenance

10b. KIND OF BUSINESS OR INDUSTRY: Cement Industry

11. BIRTHPLACE (State or foreign country): Serbia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Badrich

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-6801

17. INFORMANT — Address: Mrs. Geo. S. Badrich 307 Vista St. Hagerstown, Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis primary in
DUE TO (b): Rectal Sigmoid Colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
153.2

INTERVAL BETWEEN ONSET AND DEATH: 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obstruction & Cerebral infarct & Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 6 1950 to June 26, 1960 that (I) (we) last saw the deceased alive on June 26 1960, and that death occurred at 8:35 M, from the causes and on the date stated above.

22a. SIGNATURE: L L Packer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/28/60

22c. PHYSICIAN'S NAME (Type): L. L. Packer Sr. MD

22d. ADDRESS: 145 W. Washington St Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 29, 1960

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUN 30 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kreps

Wm. A. Horst

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7377

## CERTIFICATE OF DEATH

07360

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 421 W FRANKLIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First ROBERT — Middle VAUGHN — Last BALDWIN

4. **DATE OF DEATH**: Month JUNE — Day 10 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 7 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days 4 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: JOHN R BALDWIN

14. MOTHER'S MAIDEN NAME: PAULINE STUM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. **INFORMANT**: JOHN R BALDWIN — Address: HAGERSTOWN MD

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 773.5 — Prematurity Two Birthwt 3'10" — INTERVAL BETWEEN ONSET AND DEATH: 3 Days
DUE TO (b): Pulmonary Atelectasis Hyaline Membrane — 3 Days
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/7/60, 19____, to 6/10/60, 19____, that (I) (we) last saw the deceased alive on 6/10/60, 19____, and that death occurred at 7:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Ralph F. Young M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/11/60

22c. PHYSICIAN'S NAME (Type): RALPH F YOUNG M D

22d. ADDRESS: Williamsport, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/11/60

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City, town, or county) (State): HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S NAME: ROUZER FUNERAL HOME — Charles M Rouzer

ADDRESS: HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR DATE: JUN 20 60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2081202XV2

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) ISM 9/59

**TO HOSPITA R ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 ho after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Board of Health prior to burial, cremation, or removal, and in any event

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7378 07361

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 40 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 874 FREDERICK STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 874 FREDERICK STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEILA Middle: DAISY Last: BARBER

4. DATE OF DEATH: Month: JUNE Day: 8 Year: 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT 15 1896

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: FRANKLIN POTTER

14. MOTHER'S MAIDEN NAME: ALMA BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: SCOTT A BARBER Address: HAGERSTOWN MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
420.1
DUE TO
(b): Coronary atherosclerosis — 5 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from D. C., 19 57 to June 8, 1960, that (I) (we) last saw the deceased alive on May 24 19 60 and that death occurred at 8A M, from the causes and on the date stated above.

22a. SIGNATURE: B B Kneisley

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 10, 1960

22c. PHYSICIAN'S NAME (Type): B B KNEISLEY M D

22d. ADDRESS: 148 West Washington Street Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/10/60

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City, town, or county) (State): HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Charles M Rouzer

FUNERAL HOME ADDRESS: FUNERAL HOME HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR DATE: JUN 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kime

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7379

## CERTIFICATE OF DEATH

07362

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Hagerstown
d. STREET ADDRESS: 615 Elizabeth Avenue (Wash. Co. Hospital)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHARON — Middle LYNN — Last BARNHART

4. DATE OF DEATH: Month JUNE — Day 7 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 6, 1960
9. AGE (In years last birthday): ___ yrs. — IF UNDER 1 YEAR: Months —, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Barnhart
14. MOTHER'S MAIDEN NAME: Patsy Ann Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Henry Barnhart — Address: 615 Elizabeth Ave Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Premature birth
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 776X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 6 1960, to June 7 1960, that (I) (we) last saw the deceased alive on June 7 1960, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Louis G. Graff M.D. — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-8-60
22c. PHYSICIAN'S NAME (Type): Louis G. Graff, M.D.
22d. ADDRESS: 119 E. Antietam St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/8/60
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven
23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: A. E. Wenrich — ADDRESS: Greencastle, Penna.
25a. REC'D BY REGISTRAR DATE: JUN 10 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Knode

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
15M 9-59

2081272XV2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7380

## CERTIFICATE OF DEATH

07363

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON Co. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - CLEARSPRING
d. STREET ADDRESS: R#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle OMAR Last BLAIR

4. DATE OF DEATH: Month June Day 27 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/30/1895

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: Gen. Construction

11. BIRTHPLACE (State or foreign country): MERCERSBURG, PA.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: WARD BLAIR

14. MOTHER'S MAIDEN NAME: MARIA SHAFFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 205-09-9491

17. INFORMANT: MRS. ELSIE B. Blair
Address: Clearspring Md., R. 1

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
502.0
DUE TO
(b): Pulmonary Emphysema — unknown
DUE TO
(c): Chronic Bronchitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/23, 1960, to 6/26, 1960, that I last saw the deceased alive on 6/26, 1960, and that death occurred at 2:10 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John H Hornbaker M.D.
ADDRESS (Street, city or town, state): 154 West Washington St.
DATE SIGNED: June27, 1960

PHYSICIAN'S NAME (Type): John H. Hornbaker, M. D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/29/60
22c. NAME OF CEMETERY OR CREMATORY: BRETHREN CEM.
22d. LOCATION (City, town, or county) (State): MERCERSBURG, PA. R.2

23. FUNERAL DIRECTOR'S SIGNATURE: H. M. Bininger
ADDRESS: MERCERSBURG, PA.

24a. REC'D BY REGISTRAR DATE: JUL 5 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7381 Item 4 FilmG265 6-22-60 et

07364
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Academy Hill

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: Academy Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lewis — Middle: Mc Kay — Last: Boward

4. DATE OF DEATH: Approx. Month June Day 3, Year 1960 (Unknown 19)

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 12, 1892

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Emanuel Boward

14. MOTHER'S MAIDEN NAME: Margaret Springer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W. W. I

16. SOCIAL SECURITY NO.: 215-14-2503

17. INFORMANT: Fred Boward — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exposure - Probable — INTERVAL BETWEEN ONSET AND DEATH: Not Known
581.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ① Advanced Cirhosis Liver ② Chronic Alcoholism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No Known Injury

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): /

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE: Edward W. Ditto III M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 6/17/60

EXAMINER'S NAME (Type): Edward W. Ditto III, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-17-60
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son
ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: JUN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7382

07365

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 11 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sharpsburg Md.
d. STREET ADDRESS: 117 E. High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grafton — Middle: FinLey — Last: BRASHEARS

4. DATE OF DEATH: Month: 6 — Day: 6 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 29 1888

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: 2 — Days: 7
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Metal Assembler

10b. KIND OF BUSINESS OR INDUSTRY: Refrigeration

11. BIRTHPLACE (State or foreign country): Sharpsburg Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Thomas Brashears

14. MOTHER'S MAIDEN NAME: Sarah Peterman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219 05 2295

17. INFORMANT: Mrs. Ida Brashears — Address: 117 E. High Street Sharpsburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Lobular Pneumonia | 1 week |
| DUE TO (b) | Cerebral thrombosis | 11 weeks |
| DUE TO (c) | Cerebral arteriosclerosis | unknown |

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis, Decubiti.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 11, 1960 to June 6, 1960 that (I) (we) last saw the deceased alive on June 6, 1960 and that death occurred at 3:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Young E. Chun, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: June 6, 1960

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: 1500 Penna. Ave, Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 9-60
23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
23d. LOCATION (City, town, or county) (State): Sharpsburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf — ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE: JUN 9 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7434

## CERTIFICATE OF DEATH

07366

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MAUGANSVILLE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MAUGANSVILLE, MD.

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MAUGANSVILLE, MD.
d. STREET ADDRESS: MAUGANSVILLE, MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle G. Last BURKHOLDER

4. DATE OF DEATH: Month JUNE Day 24 Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/20/1873
9. AGE (In years lost birthdoy): 87 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): MAUGANSVille, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN E. HORST
14. MOTHER'S MAIDEN NAME: ANNA GOOD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Edgar H. Burkholder — Address RD2 Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 8 yr.
420.0
DUE TO
(b)
Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Manth, Doy, Year 19
20d. INJURY OCCURRED While at work ☐ Nat while ot work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, affice bldg., etc.)
20f. (City or tawn) (Caunty) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 1952, to June 24, 1960, that (I) (we) last saw the deceased alive an June 23 1960 and that death occurred at 2:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: B. B. Kneisley M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/25/60
22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
22d. ADDRESS: 148 West Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/27/60
23c. NAME OF CEMETERY OR CREMATORY: MILLERS MENNONITE Cem.
23d. LOCATION (City, town, or county) (State): Near Leitersburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: A.E. Minnich
ADDRESS: Greencastle, Penna.
25a. REC'D BY REGISTRAR DATE: JUN 27 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7383 **CERTIFICATE OF DEATH** Reg. Dist. No. 07367

1. PLACE OF DEATH
a. COUNTY [redacted] Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 1 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 BELVIEW AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE PA.
b. COUNTY FRANKLIN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X FT. LOUDON, PA.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Byers
4. DATE OF DEATH Month June Day 7, Year 1960
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2/9/1890
9. AGE (In years last birthday) 70 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) RICHMOND FURNACE, PA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME FRAKER BYERS
14. MOTHER'S MAIDEN NAME SARAH HAISTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 204-03-7701
17. INFORMANT Address CLYDE E. Byers, St. THOMAS, PA., R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 1 hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertension, Arteriosclerotic Heart Dz. — 25 yrs.
DUE TO (c)
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

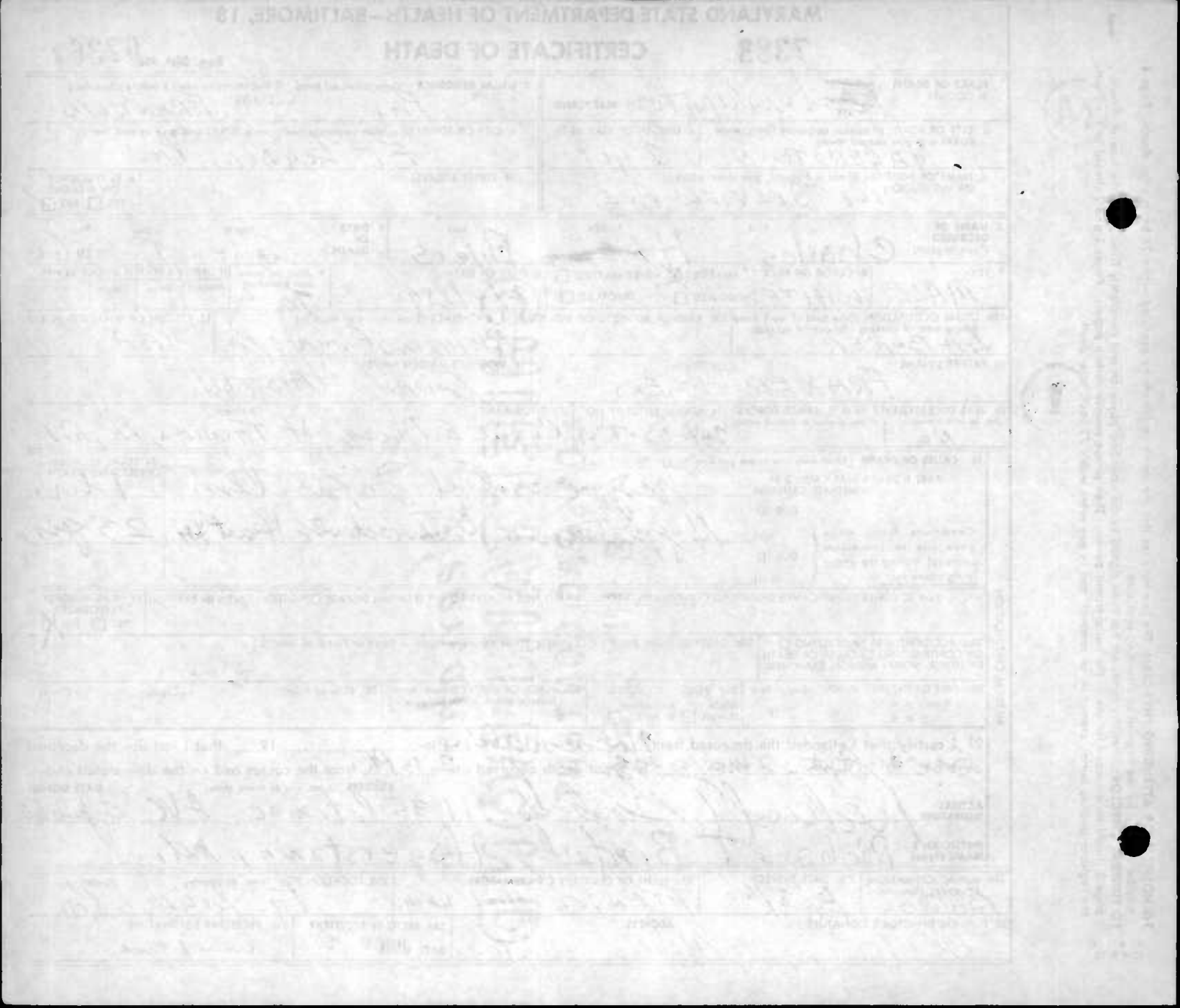
21. I certify that I attended the deceased from Not seen alive to _____, 19____, that I last saw the deceased alive on June 2 1960, that death occurred at 2:15 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE, M.D. Richard F. Bixler
ADDRESS (Street, city or town, state) 1135 Potomac Ave
DATE SIGNED 5 Jun 60
PHYSICIAN'S NAME (Type) Richard F. Bixler Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 6/8/60
22c. NAME OF CEMETERY OR CREMATORY STENGER HILL CEM.
22d. LOCATION (City, town, or county) (State) FT. LOUDON, PA.

23. FUNERAL DIRECTOR'S SIGNATURE J. M. Brininger ADDRESS Mercersburg, Pa.
24a. REC'D BY REGISTRAR DATE JUN 9 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kranz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7455 — 07368 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): nr. Charlton
c. LENGTH OF STAY IN 1b: 30 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. — b. COUNTY: Berkeley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Falling Waters RFD #1
d. STREET ADDRESS: Falling Waters RFD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Nardi | Leo | Ceravalo | June | 26 | 1960 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | NEVER MARRIED ☒ | Nov. 13 1932 | 27 yrs. | 7 / 12 | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farm Hand | Farm | Falling Waters RFD | U.S.A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Dominick Ceravalo | Julia Allen |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No | 234 54 9897 | Mrs. Kathleen Jones | Falling Waters W. Va. RFD #1 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: Immed.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

850X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell from boat into water while fishing.

| 20c. TIME OF INJURY Hour | Month, Day, Year | 20d. INJURY OCCURRED While at work / Not while at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|---|
| 7 25 p. m. | 6/26/1960 | Not while at work ☒ | Potomac River | nr. Charlton | Wash. | Md |

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward W. Dilla III, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☐ — DATE SIGNED: 6/28/60

EXAMINER'S NAME (Type)

| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | June 29-60 | Harmony Cemetery | Near Marlowe W. Va. |

| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR DATE | 24b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Edith V. Leaf | Edwards Funeral Home Inc. Hancock Md | JUN 30 '60 | Arthur S. Krauss |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7429

## CERTIFICATE OF DEATH

07369
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 5yrs. 5mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown, Route #5
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

090

3. NAME OF DECEASED (Type or print): First: Sarah; Middle: Margaret; Last: Clopper

4. DATE OF DEATH: Month: June; Day: 2; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Aug 16, 1861

9. AGE (In years last birthday): 98 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frederick County

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Hessong

14. MOTHER'S MAIDEN NAME: Matilda Kline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

INFORMANT Address: Mrs. A. Toms (daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio - Respiratory Colapse — INTERVAL BETWEEN ONSET AND DEATH: 1 min

DUE TO (b): Generalized Cachexia — 1 mo

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

794X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fx hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1958, to June 2, 1960 that I last saw the deceased alive on June 1, 1960, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: M E Byrkit M.D.
ADDRESS (Street, city or town, state): 28 W Potomac
DATE SIGNED: 6-3-60

PHYSICIAN'S NAME (Type): M E Byrkit
Williamsport Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-5-60
22c. NAME OF CEMETERY OR CREMATORY: Leitersburg Cemetery
22d. LOCATION (City, town, or county) (State): Leitersburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Smithsburg, Md

24a. REC'D BY REGISTRAR DATE: JUN 10 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7384 **CERTIFICATE OF DEATH** Reg. Dist. No. 07370

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 133 Fairground Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JENNINGS — Middle BRYAN — Last CONSTABLE

4. DATE OF DEATH: Month June — Day 10 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 31, 1895

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Cement mfg.

11. BIRTHPLACE (State or foreign country): Inkerman, W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas F.Constable

14. MOTHER'S MAIDEN NAME: Mary Virginia Shadwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 224-10-9465

INFORMANT: Mrs.J.B.Constable 133 Fairground Ave. — Address: Hagerstown, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Hours

420.9

DUE TO (b): Arter-sclerotic Heart D. — Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1961, to June 10, 1960, that I last saw the deceased alive on June 10, 1960, and that death occurred at 9:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sidney Provenstein M.D. — ADDRESS (Street, city or town, state): Funkstown Md — DATE SIGNED: 6-11 60

PHYSICIAN'S NAME (Type): SIDNEY PROVENSTEIN — Funkstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 13, 1960

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: JUN 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kinnard

Wm. A. Hoss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07971

7436

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural 2 Hancock Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Little Pool Near Hancock Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural 1 Hancock Md.
d. STREET ADDRESS: Rural 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donald — Middle: Sparr — Last: Dickerhoff

4. DATE OF DEATH: Month: 6.5. — Day: — Year: 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9.23.1922

9. AGE (In years last birthday): 37 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: House Painting

11. BIRTHPLACE (State or foreign country): Washington County Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elmer E Dickerhoff

14. MOTHER'S MAIDEN NAME: Bessie E Heller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ann M Dickerhoff Address: Rural 1 Hancock Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DROWNING — INTERVAL BETWEEN ONSET AND DEATH: instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

929.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Tried to Rescue Fellow Fisherman

20c. TIME OF INJURY: Hour: 3.35 a. m. — Month, Day, Year: 6-5 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Camp

20f. (City or town): Hancock (County): Washington (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: J. W. Otto M.D.
EXAMINER'S NAME (Type): J W Otto Jr

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 6/5/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6.8.60
22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
22d. LOCATION (City, town, or county) (State): Hancock Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F Stone — ADDRESS: Hancock md

24a. REC'D BY REGISTRAR DATE: JUN 9 '60

24b. REGISTRAR'S SIGNATURE: Charles L. Truax

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—~~BALTIMORE 18~~

# CERTIFICATE OF DEATH

7437

07372

Reg. Dist. No.

**1. PLACE OF DEATH**

COUNTY Washington — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport - RFD

LENGTH OF STAY (in this place) 7 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Church Home

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Md COUNTY Frederick

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick

STREET ADDRESS (If rural give location) 14 East 5th St.

**3. NAME OF DECEASED** (Type or Print) (First) Anna (Middle) Mary (Last) Dieterich

**4. DATE OF DEATH** (Month) June (Day) 30 (Year) 1960

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Single | Oct 21, 1885 | 74 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Frederick

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Justus Dieterich

14. MOTHER'S MAIDEN NAME Anna Catherine Gerlach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS Mrs. Wagner, R# 2 Williamsport, Md.

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170 IMMEDIATE CAUSE (A) Cardiac arrest Coronary

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Carcinoma of the breast DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: (A) Min. (B) Yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

**22. I hereby certify** that I attended the deceased from Oct, 19 59, to June 30, 19 60, that I last saw the deceased alive on June 29, 19 60, and that death occurred at 7:20 A.M., on June 30th from the causes and on the date stated above.

SIGNATURE Louis Hall M.D. ADDRESS (Street, city, town, state) 119 E. Church Hagerstown Md DATE SIGNED 6/30/60

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | July 2, 1960 | Mt. Olivet Cemetery | Frederick, Maryland |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| JUL 6 '60 | Clifton S. Kinna | Robert E. Bailey | Frederick, Maryland |

Item 18 Film 262 2 15 60 875

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7430

Reg. Dist. No. 07373

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rear Of 24 Potomac Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: Rear Of 24 Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Melton — Middle: Samuel — Last: Ditlow

4. DATE OF DEATH: Month: June — Day: 28 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABOR

10b. KIND OF BUSINESS OR INDUSTRY: Power Plant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William Ditlow

14. MOTHER'S MAIDEN NAME: Mary Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220 09 9010

17. INFORMANT: Mary E. Ditlow — Address: 820 Washington Ave. Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pyelonephritis with cortical necrosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Pyelitis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 600.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): adenocarcinoma prostate ⊙ Benign Prostatic hypertrophy ⊙ Total urinary retention

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Edward W. Ditto III M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Edward W. Ditto III, M. D.
DATE SIGNED: 6/29/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 30-60
22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Edith V. Leal — ADDRESS: Williamsport Md

24a. REC'D BY REGISTRAR DATE: JUL 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7438

## CERTIFICATE OF DEATH

07374

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown RFD #3
c. LENGTH OF STAY IN 1b: 19 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oak Ridge Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown R.F.D #3
d. STREET ADDRESS: Oak Ridge Drive
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Annie; Middle: Camilla; Last: Dorsey

4. DATE OF DEATH: Month: June; Day: 19; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Feb. 18 1900

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: 4; Days: 1
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crop Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Lloyd C. Weaver

14. MOTHER'S MAIDEN NAME: Fannie Mc Namee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215 36 7081

17. INFORMANT: Mr. Carl Dorsey
Address: 2204 Gay St. Hagerstown Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

254X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Arteriosclerotic heart disease — 10 years

DUE TO (c): Toxic thryoiditis — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1934 19___ to 6.19.60 19___, that (I) (we) last saw the deceased alive on 6.19.60 19___, and that death occurred at 3. P.M. from the causes and on the date stated above.

22a. SIGNATURE: Earl Young M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 6.20.60

22c. PHYSICIAN'S NAME (Type): S. Earl Young M.D.

22d. ADDRESS: 148 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 21-60

23c. NAME OF CEMETERY OR CREMATORY: Manor Cemetery

23d. LOCATION (City, town, or county): Near Tilghmanton (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edith V. Long

ADDRESS: Williamsport Md.

25a. REC'D BY REGISTRAR DATE: JUN 22 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7385

07375 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 1 MONTH
d. NAME OF HOSPITAL (If not in hospital, give street address): 218 WOODPOINT AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 218 WOODPOINT AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LULU Middle CATHERINE Last DUTROW

4. DATE OF DEATH: Month JUNE Day 18 Year 19 60

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/8/1881
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM D. ENGLEBERGER
14. MOTHER'S MAIDEN NAME: ADELLA M. MILLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
INFORMANT: MILLARD G. DUTROW Address: (SAME AS ITEM #1)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO
(b): Generalized Arteriosclerosis — Years
DUE TO
(c):

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1960, to June 18, 1960 that I last saw the deceased alive an June 17, 1960, and that death occurred at 9 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A.Bell M.D.
ADDRESS (Street, city or town, state): 119 North Potomac St.
DATE SIGNED: 6-18-60
PHYSICIAN'S NAME (Type): R.A.Bell, M.D.
Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/20/60
22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEM.
22d. LOCATION (City, town, or county) (State): FREDERICK MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment, Hagerstown Md.
ADDRESS
24a. REC'D BY REGISTRAR DATE: JUN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7386

07376

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 855 Summit Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Magdalene; Middle: Caroline; Last: Eiler

4. DATE OF DEATH: Month: June; Day: 1; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 18, 1891

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hag. Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles E. Eckstine

14. MOTHER'S MAIDEN NAME: Flora A. Stockslager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Murray E Eiler 855 Summit Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombosis of rt int. carotid artery — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(b): Atherosclerosis of vessel — ?
DUE TO
(c):

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 30 May 1960 to 1 June 1960, that (I) (we) last saw the deceased alive on 1 June 19 60 and that death occurred at 3 P M, from the causes and on the date stated above.

22a. SIGNATURE: Eldon Hoachlander M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/3/60

22c. PHYSICIAN'S NAME (Type): Eldon S Hoachlander

22d. ADDRESS: Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 4/60

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUN 6 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07377

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cascade
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Hawn Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa.
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 344 S. Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura; Middle: Ellen; Lost: Eyler

4. DATE OF DEATH: Month: June; Day: 26,; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 13, 1879

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): New Oxford, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James A. Sadler

14. MOTHER'S MAIDEN NAME: Harriet Herman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Mrs. Kathryn C. Garner, Address: 344 S. Potomac, St. Waynesboro, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour.
DUE TO
(b): Arteriosclerotic Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH: 10 years.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4-20.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 9, 19 60, to June 26, 19 60 that I last saw the deceased alive an June 25, 19 60, and that death occurred at 6:12 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Shafer M.D. ADDRESS (Street, city or town, state): Blue Ridge Summit, Pa. DATE SIGNED: 27 June 60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 29, 1960
22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
22d. LOCATION (City, town, or county) (State): Emmitsburg, Frederick Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. E. Wilson
ADDRESS: Emmitsburg, Md.
C. E. Wilson

24a. REC'D BY REGISTRAR DATE: JUL 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7440

## CERTIFICATE OF DEATH

07378
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg
c. LENGTH OF STAY IN 1b: 45 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 29 W. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg
d. STREET ADDRESS: 29 W. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George; Middle: Washington; Last: Ferguson

4. DATE OF DEATH: Month: June; Day: 15; Year: 19 60

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 4, 1880

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: self-employed

11. BIRTHPLACE (State or foreign country): Ringgold, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John H. Ferguson

14. MOTHER'S MAIDEN NAME: Anna B. Wolfe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-20-1832

INFORMANT: Mrs. Nannie M. Ferguson, Address: Smithsburg, M

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO
(b): Arteriosclerotic Cardiovascular Disease — 10 Yrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 12/10, 19 54, to 6/15, 19 60 that I last saw the deceased alive on 6/15, 19 60, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Hess M.D.
ADDRESS (Street, city or town, state): Smithsburg, Md.
DATE SIGNED: 6/16/60

PHYSICIAN'S NAME (Type): Charles F. Hess M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6-18-60
22c. NAME OF CEMETERY OR CREMATORY: Smithsburg, Cemetery
22d. LOCATION (City, town, or county) (State): Smithsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

24a. REC'D BY REGISTRAR DATE: JUN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kines

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7441 — Reg. Dist. No. 07379

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6 miles west on Rt. 40

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chambersburg 75x-3
d. STREET ADDRESS: 1317 S. 4th. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: E. — Last: Florig, Jr.
4. DATE OF DEATH: Month: June — Day: 12, — Year: 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 10, 1934
9. AGE (In years last birthday): 25 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lift operator
10b. KIND OF BUSINESS OR INDUSTRY: Machine Mfg.
11. BIRTHPLACE (State or foreign country): Chambersburg, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Florig
14. MOTHER'S MAIDEN NAME: Kathleen Flora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 186-28-5379
17. INFORMANT: Charles E. Florig, 1317 S. 4th. Address: Chambersburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): FRACTURED CERVICAL SPINE — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
821X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): THROWN FROM MOTOR-CYCLE WHILE SPEEDING - HAG. SPEEDWAY
20c. TIME OF INJURY: Hour: o. m. / p. m. 2:50 — Month, Day, Year: 6/12/60
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): SPEEDWAY 6 MI. WEST OF HAGERSTOWN, MD (County): Wash. (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): DR. E. W. DITTO, JR
DATE SIGNED: 6/13/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/16/60
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Lincoln
22d. LOCATION (City, town, or county): Chambersburg (State): Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Fun. Home — ADDRESS:
24a. REC'D BY REGISTRAR DATE: JUN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7387

# CERTIFICATE OF DEATH

07380 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Leitersburg
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle ABNER — Last FUNK
4. DATE OF DEATH: Month June — Day 20 — Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 14,1906
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Houses etc.
11. BIRTHPLACE (State or foreign country): Strasburg,Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Funk
14. MOTHER'S MAIDEN NAME: Elizabeth Bailey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1921 - 1925
16. SOCIAL SECURITY NO.: 223-20-4153
INFORMANT — Address: Mrs.Wm.A.Funk Leitersburg,Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pulmonary Edema and Congestion | 7 days |
| DUE TO (b) | Cor Pulmonale decompensated | 10 yrs |
| DUE TO (c) | Pulmonary Emphysema Severe | 15 yrs |

527.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 16, 1960 to JUNE 20, 1960 that I last saw the deceased alive on JUNE 20, 1960, and that death occurred at 7.10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. R. Laddizabal M.D. — ADDRESS (Street, city or town, state): 12 South Main St — DATE SIGNED: 6-22-60

PHYSICIAN'S NAME (Type): E R Laddizabal M.D. — Smithsburg Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 23,1960
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown,Md.
24a. REC'D BY REGISTRAR DATE: JUN 24 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Thams

Wm. G. Hott

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

M

081

Under a n* Assumed name

0

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7431

# CERTIFICATE OF DEATH

07381

Reg. Dist. No. 07381

1. PLACE OF DEATH — a. COUNTY: Washington Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WILLIAMSPORT SANITARIUM

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: FRANKLIN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro 75X-3
d. STREET ADDRESS: 420 South Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: K. — Last: Gearhart

4. DATE OF DEATH: Month: June — Day: 13 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 15, 1876

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTOR

10b. KIND OF BUSINESS OR INDUSTRY: CEMENT

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Martin J. Gearhart

14. MOTHER'S MAIDEN NAME: Catherine Welty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

INFORMANT: Mrs. Arthur Eyler — Address: 409 S. Potomac St. Waynesboro, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion & Myocardial infarct 15 min.
DUE TO (b): Generalized Atherosclerosis
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 24, 1960, to June 13, 1960 that I last saw the deceased alive on May 30, 1960, and that death occurred at 11 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M E Bykit M.D.
ADDRESS (Street, city or town, state): 28 W Potomac
DATE SIGNED: 6-13-60

PHYSICIAN'S NAME (Type): M E Bykit
Williamsport Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 16, 1960
22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
22d. LOCATION (City, town, or county) (State): Waynesboro Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: S. Marlin Doe
ADDRESS: Waynesboro, Penna.

24a. REC'D BY REGISTRAR DATE: JUN 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

Item 18 Film 265 6-28-60 ams

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07382

7388

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Unknown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): rear 518 Mitchell Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 510 Salem Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle RAYMOND Last GLADHILL

4. DATE OF DEATH: Month June Day 7 Year 1960

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 20 1907

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Md. Hagerstown Wash Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles R. Gladhill

14. MOTHER'S MAIDEN NAME: Linnie Eyerly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W#2

16. SOCIAL SECURITY NO.: 214-09-7667

17. INFORMANT: Charles R. Gladhill Address: 510 Salem Ave Hagerstown, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ____ — INTERVAL BETWEEN ONSET AND DEATH: ____
DUE TO (b): General Arteriosclerosis — Recent
DUE TO (c): ____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): DREW DITTO Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/9/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/9/60
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md

24a. REC'D BY REGISTRAR DATE: JUN 13 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7389 **CERTIFICATE OF DEATH** 07384 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 35 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 840 VIRGINIA AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
d. STREET ADDRESS 840 VIRGINIA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First BEATRICE Middle IRENE Last GRIFFITH
4. DATE OF DEATH Month JUNE Day 29 Year 60 19

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10/19/1909
9. AGE (In years last birthday) 50
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN MILLER
14. MOTHER'S MAIDEN NAME DAISY STITLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
INFORMANT MR. HARRY GRIFFITH Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(b) Ca breast — 5 1/2 s
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from ____, 1959, to June, 1960, that I last saw the deceased alive on June 27, 1960, and that death occurred at 7 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Howard N. Weeks M.D. ADDRESS (Street, city or town, state) 136 N Potomac DATE SIGNED 6/30/60
PHYSICIAN'S NAME (Type) Howard N. Weeks

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 7/1/60
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE W. J. Rowland, Hagerstown, Md. ADDRESS
24a. REC'D BY REGISTRAR DATE JUL 5 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Hawn

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7390

## CERTIFICATE OF DEATH

07385
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 10 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) 1816 GILBERT AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MATYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
d. STREET ADDRESS 1816 GILBERT AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First FAY Middle WILSON Last GUM
4. DATE OF DEATH Month JUNE Day 22 Year 19 60

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10/ 8/1922
9. AGE (In years last birthday) 37 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOSEPH GUM
14. MOTHER'S MAIDEN NAME DORA SWICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) YES (If yes, give war or dates of service) W.W. #2
16. SOCIAL SECURITY NO. 216-18-1627
INFORMANT MRS. JESSIE B. GUM Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 wks
420.0
DUE TO (b) Arteriosclerotic Heart Disease — 3 mo+
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 4, 1960, to June 18, 1960, that I last saw the deceased alive on June 18, 1960, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Lloyd A. Hoffman M.D. ADDRESS (Street, city or town, state) 214 N. Potomac St. DATE SIGNED 6/23/60
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 6/24/60
22c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN CEM.
22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment ADDRESS Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE JUN 27 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7391

## CERTIFICATE OF DEATH

07386

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 107 Linden Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWIN — Middle STEPHEN — Last GUTH

4. DATE OF DEATH: Month June — Day 25 — Year 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 8, 1884

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Commissioner

10b. KIND OF BUSINESS OR INDUSTRY: City Works Board

11. BIRTHPLACE (State or foreign country): Ironton, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alexander A. Guth

14. MOTHER'S MAIDEN NAME: Sarah Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 213-10-6935

17. INFORMANT: Mrs. Sadie C. Guth — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO (b): Coronary Sclerosis — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Heart Disease — Unknown

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 20, 1953, to June 25, 1960 that (I) (we) last saw the deceased alive on June 25 1960, and that death occurred at 10:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: L. L. Packer Jr M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/27/60

22c. PHYSICIAN'S NAME (Type): L. L. Packer Sr M.D.

22d. ADDRESS: 145 W. Washington St Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/28/1960

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home — R. Franklin Rouzer

ADDRESS: Hagerstown, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 29 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7392

07387

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 31 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1224 Pinecrest Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle DELL Last HARVEY

4. DATE OF DEATH: Month June Day 15 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 7, 1895

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Colton, W. Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Wyatt

14. MOTHER'S MAIDEN NAME: Amanda Mc Quain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 406-38-2156

17. INFORMANT: Mr. James C. Hartsaw Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic heart disease c
DUE TO: coronary insufficiency & hypertension
(b):
DUE TO:
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

INTERVAL BETWEEN ONSET AND DEATH: 5 date years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): diabetes

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/18/60, 19___, to 6/15/60, 19___, that (I) (we) last saw the deceased alive on 6/15/60, 19___, and that death occurred at 11:35 AM, from the causes and on the date stated above.

22a. SIGNATURE: H. N. Weeks M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/17/60

22c. PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D.

22d. ADDRESS: 136 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/18/1960

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home — R. Franklin Rouzer

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUN 20 '60

25b. REGISTRAR'S SIGNATURE: Carrie S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7393

07388

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: FREDERICK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FREDERICK
d. STREET ADDRESS: WATKINS ACRES APTS.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1011.2

3. NAME OF DECEASED (Type or print): First MARGARET — Middle SUE — Last HIGUCHI

4. DATE OF DEATH: Month JUNE — Day 17 — Year 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/15/60

9. AGE (In years last birthday): — yrs.

IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS.: Hours 12 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: KIYOSHI HIGUCHI

14. MOTHER'S MAIDEN NAME: THELMA TAKEDA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

INFORMANT: MR. KIYOSHI HIGUCHI — Address: FREDERICK MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis
DUE TO (b): Prematurity 2 lbs 4 oz
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

>62.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Toxemia Mother (Chronic Nephritis)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/15/, 1960, to 6/17/, 1960, that I last saw the deceased alive on 6/17/, 1960, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. M. Bacon Jr. M.D. — ADDRESS (Street, city or town, state): 101 King St Hagerstown Md — DATE SIGNED: 6/

PHYSICIAN'S NAME (Type): A. M. BACON JR

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

22b. DATE THEREOF: 6/18/60

22c. NAME OF CEMETERY OR CREMATORY: LOUDEN PARK CREM.

22d. LOCATION (City, town, or county) (State): BALTIMORE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: JUN 20 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2081381 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7394

07389

1

DR. KEADLE 318 N. POTOMAC ST. HAGERSTOWN

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 18 YEARS
   d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 124 EAST FIRST STREET

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
   d. STREET ADDRESS: 124 EAST FIRST STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ALVA Middle LUTHER Last HUTZEL

4. **DATE OF DEATH**: Month JUNE Day 18 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT-4-1881

9. AGE (In years lost birthday): 78 yrs. — IF UNDER 1 YEAR: Months 9, Days 14 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MACHINE OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: STATTON FURNITURE MFG. Co.

11. BIRTHPLACE (State or foreign country): FRED. Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL E. HUTZEL

14. MOTHER'S MAIDEN NAME: EMMA McBRIDE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-5874

17. **INFORMANT**: AUSTIN W. HUTZEL — Address: 825 S. POTOMAC ST. HAGERSTOWN MD. R.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Ventricular fibrillation | minutes |
| DUE TO (b) | Myocardial infarction | 36 hours. |
| DUE TO (c) | Arteriosclerotic heart disease | Indefinite. |

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from February 1959 to death, 19___, that (I) (we) last saw the deceased alive on June 16, 1960, and that death occurred at 6:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert F. Keadle M.D.

ATTENDING PHYS. X MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 18, 1960

22c. PHYSICIAN'S NAME (Type): Robert F. Keadle

22d. ADDRESS: Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE-20-1960

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City, town, or county) (State): HAGERSTOWN WASH. Co. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John W. Bast

ADDRESS: BOONSBORO WASH. Co. MD

25a. REC'D BY REGISTRAR DATE: JUN 22 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7442 — 07390 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Boonesboro
c. LENGTH OF STAY IN 1b: 15½ Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Keedy Fahrney Memorial Home Boonesboro Md., #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Smithsburg
d. STREET ADDRESS: Smithsburg #2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Harris — Last: Ingram

4. DATE OF DEATH: Month: June — Day: 26, — Year: 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 27, 1864
9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Orchard owner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Luenenburg, Nova Scotia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Silas W. Ingram
14. MOTHER'S MAIDEN NAME: Melissa Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ray F. Ingram — Address: Smithsburg Md., #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO (b): Carcinoma of left side of face — 6 months
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 191.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 6, 1960, to June 26, 1960, that I last saw the deceased alive on June 25, 1960, and that death occurred at 5:14 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G W Wehrly M.D. — ADDRESS (Street, City or town, state): Boonsboro Md. — DATE SIGNED: 6/25/60

PHYSICIAN'S NAME (Type): G. W. Wehrly

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/29/60
22c. NAME OF CEMETERY OR CREMATORY: Hillside
22d. LOCATION (City, town, or county) (State): Plainfield N.J.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter J. Hoar — ADDRESS: Waynesboro, Pa
24a. REC'D BY REGISTRAR DATE: JUN 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7395 **CERTIFICATE OF DEATH** 07391

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital
d. STREET ADDRESS: 1600 Jefferson Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mildred Middle Elsie Last Itneyer
4. DATE OF DEATH: Month June Day 7, Year 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 25, 1912
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mail sorter
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Post Office
11. BIRTHPLACE (State or foreign country): near Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clyde B. Itneyer
14. MOTHER'S MAIDEN NAME: Lulu Neff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Address: Mrs. Nellie Lytton, Hagerstown, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO
(b): Carcinoma of the uterus, original site — 17 mo.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1959, to June 7, 1960, that I last saw the deceased alive on June 7, 1960, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. B. Kneisley M.D.
ADDRESS (Street, city or town, state): 148 West Washington St. Hagerstown, Maryland
DATE SIGNED: 6/8/60
PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6-10-60
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: JUN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG266 7-6-60 et

7396

# CERTIFICATE OF DEATH

Reg. Dist. No 07392

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b: 35yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland.
d. STREET ADDRESS: 644 Penna. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Henry — Last: Johnson

4. DATE OF DEATH: Month: 6 — Day: 23 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 12 1872 (1872 / 1882)

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: gardener

11. BIRTHPLACE (State or foreign country): Falling Waters W.Va. USA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles H. Johnson

14. MOTHER'S MAIDEN NAME: Tobiasee Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-42-1359

17. INFORMANT — Address: Reginald Johnson 125 W Church Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): ne fibrosclerosis & gen'l arteriosclerosis — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

44-6X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malnutrition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/4/60, 19____, to 6/23/60, 19____, that I last saw the deceased alive on 6/23/60, 19____, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard N. Weeks, M.D. — ADDRESS (Street, city or town, state): 136 N. Potomac St., Hagerstown, Md. — DATE SIGNED: 6/25/60

PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-27-1960

22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

22d. LOCATION (City, town, or county) (State): Williamsport Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John R Watson Jr. Hagerstown Md.

24a. REC'D BY REGISTRAR — DATE: JUN 30 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7397 **CERTIFICATE OF DEATH** Reg. Dist. No. 07393

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b: 57 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY "ashington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. STREET ADDRESS: 717 Virginia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle Allen Last Keifer
4. DATE OF DEATH: Month June Day 14 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 14, 1883
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard
10b. KIND OF BUSINESS OR INDUSTRY: Aircraft Industry
11. BIRTHPLACE (State or foreign country): Cascade Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Cyrus Keifer
14. MOTHER'S MAIDEN NAME: Missouri Harbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-09-4025
INFORMANT: Mrs. Minnie M. Keifer Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma to brain — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
163X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) Primary carcinoma of lung — 4 months
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fusiform arteriosclerotic abdominal aortic aneurysm
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 26, 1960, to June 14, 1960, that I last saw the deceased alive an June 13, 1960, and that death occurred at 6:10 M, from the causes and an the date stated above.
ACTUAL SIGNATURE John C. Stauffer M.D.
ADDRESS (Street, city or town, state) DATE SIGNED 6/14/60
PHYSICIAN'S NAME (Type) John C. Stauffer 145 S. Prospect, Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 16, 1960
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE JUN 17 '60
24b. REGISTRAR'S SIGNATURE: Clifton L. Kline

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7398 07394

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 55 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1859 Virginia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD — Middle DAVIS — Last KERFOOT

4. DATE OF DEATH: Month June — Day 28 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1891

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Yard Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Washington Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Jacob Kerfoot

14. MOTHER'S MAIDEN NAME: Anna E. Arthur

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-10-5023

17. INFORMANT: Robert Kerfoot — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute left ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: Few minutes
DUE TO (b): Hypertensive-arteriosclerotic Heart Disease — Unknown (many years)
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-1 1950 to 6/28 1960 that (I) (we) last saw the deceased alive on 6/28 1960, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John H. Hornbaker M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6:29:60

22c. PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D.

22d. ADDRESS: 154 West Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/1/1960
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home — P. Franklin Rouzer
ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 5 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kines

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7399

# CERTIFICATE OF DEATH

07396

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 40 YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 838 FREDERICK ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 838 FREDERICK ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTIE — Middle LARUE — Last LANTZ

4. DATE OF DEATH: Month JUNE — Day 8 — Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 3. 1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months 5 Days 5
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): HANOVER PENNA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM YANTIS
14. MOTHER'S MAIDEN NAME: MARGARET YANTIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: FRANK TANGER — Address: 838 FREDERICK ST HAGERSTOWN MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CA - Myocardial deficiency — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/7/60 19___ to 6/8/60 19___, that (I) (we) last saw the deceased alive on 6/8/60 19___, and that death occurred at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ralph Young M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/9/60
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JUNE 11. 1960
23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
23d. LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John W. Rast — ADDRESS: BOONSBORO MD.
25a. REC'D BY REGISTRAR DATE: JUN 13 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 M Hagerstown
X Williamsport MD
I
0
1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7432

# CERTIFICATE OF DEATH

07397
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Williamsport Saniatarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia — b. COUNTY: Berkeley
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Martinsburg, Route # 2 RURAL
d. STREET ADDRESS: Route # 2 — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Jacob — Middle: Henry — Last: Lingamfelter
4. DATE OF DEATH: Month: June — Day: 28 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: September 5,1882
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Charles Lingamfelter
14. MOTHER'S MAIDEN NAME: Annabell Small

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs. W. Hoge Light, Martinsburg, Rt 2 — Address

## MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3wks
DUE TO (b): Arterio-sclerosis — 5 yrs
DUE TO (c): (First Stroke July 10, 1957 — 3 yrs.

Conditions, if ony, which gave rise to immediote cause (a), stating the under-lying cause last.

3 3/4 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Interstitial Nephritis 2 yrs.
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1957, to June 28, 1960, that I last saw the deceased alive an June 28, 1960, and that death accurred at 5:20 P.M., from the causes and an the date stated abave.

ACTUAL SIGNATURE: Victor L. Glover M.D. — ADDRESS (Street, city or town, state): 407 W. King St Martinsburg, W Va — DATE SIGNED: 6-28-60
PHYSICIAN'S NAME (Type): VICTOR L. GLOVER, M.D. — MARTINSBURG, W. Va

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 1,1960
22c. NAME OF CEMETERY OR CREMATORY: West Alexander Cemetery
22d. LOCATION (City, town, or county) (State): West Alexander, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Estelle V. Leaf — ADDRESS: Wil-
24a. REC'D BY REGISTRAR DATE: JUL 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar ta burial, cremation, ar removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7433

07398 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport
d. STREET ADDRESS: 114 west Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle Wesley Last Lizer

4. DATE OF DEATH: Month June Day 2 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 15, 1877

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months 6 Days 14
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boatsman

10b. KIND OF BUSINESS OR INDUSTRY: Canal

11. BIRTHPLACE (State or foreign country): Williamsport, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Joseph Lizer

14. MOTHER'S MAIDEN NAME: Amelia Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT Address: George L. Lizer (Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Diffuse Arteriosclerosis — 20 yrs
DUE TO (c):

331x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1958 to [illegible] 1960 that I last saw the deceased alive on June 2, 1960 and that death occurred at 12:38 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M E Byrkit M.D. — ADDRESS (Street, city or town, state): 28 W Potomac — DATE SIGNED: 6-3-60

PHYSICIAN'S NAME (Type): M E Byrkit — Williamsport Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 4-60

22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert Leaf — ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: JUN 6 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07399

7400

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 17 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 333 S.Mulberry St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLIS — Middle: PORTER — Last: LYNCH

4. DATE OF DEATH: Month: June — Day: 27 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec.20,1896

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Aircraft

11. BIRTHPLACE (State or foreign country): Fulton County, Penna.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Biddis Lynch

14. MOTHER'S MAIDEN NAME: Della Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-18-2765

INFORMANT — Address: Mrs.E.P.Lynch 333 S.Mulberry St.Hagerstown,Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: Immed.

DUE TO

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b) General arteriosclerosis and Cerebral — 2-4 yrs

DUE TO

(c) arteriolarsclerosi

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

① chr. pancreatitis ② Healed gastric ulcer ③ Prostate hypertrophy, Benign

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1, 1959 to June 22, 1960, that I last saw the deceased alive on June 22, 1960, and that death occurred at 9:37 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto III, M.D. — ADDRESS (Street, city or town, state): 217 West Washington Street — DATE SIGNED: 6/28/60

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M. D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/29/60

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown,Md.

24a. REC'D BY REGISTRAR DATE: JUN 30 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Wm. C. Hoak

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7401

## CERTIFICATE OF DEATH

07400
Reg. Dist. No.

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

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DP

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 6 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): 321 S. CANNON AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 321 S. CANNON AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle PRUDENCE Last MAGAHA

4. DATE OF DEATH: Month JUNE Day 23 Year 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/4/1880

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS BRASHEARS

14. MOTHER'S MAIDEN NAME: SARAH PETERMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

INFORMANT: MISS EVA CHURCHEY
Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 422.1 Cardiovascular Collapse
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Arteriosclerosis Gen
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Yrs. Mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Doy Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/15, 19 60, to 6/23, 19 60 that I last saw the deceased alive on 6/22, 19 60, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis Gruff M.D.
ADDRESS (Street, city or town, state): 119 E. Antietam St Hagerstown Md.
DATE SIGNED: 6/24/60
PHYSICIAN'S NAME (Type): Louis G. Gruff M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/26/60
22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEM.
22d. LOCATION (City, town, or county) (State): FERDERICK MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR
DATE: JUN 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7443

## CERTIFICATE OF DEATH

07401

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) HAGERSTOWN
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GATEWAY NURSING HOME

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — COUNTY: BERKELEY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) INWOOD
d. STREET ADDRESS: Rt. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

85X-3

3. **NAME OF DECEASED** (Type or print): First ELLA — Middle MAE — Last MASTERS

4. **DATE OF DEATH**: Month JUNE — Day 21 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 28, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months 2 — Days 24
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Duties

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Berkeley Co., W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ralph Parkinson

14. MOTHER'S MAIDEN NAME: Emily Katherine Shade

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: J. D. Masters — Address: Inwood, Rt. # 1, W. Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

724 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Articular Rheumatism — 3 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bilateral Pulmonary Tuberculosis — arrested

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 5, 1958, to June 21, 1960, that (I) (we) last saw the deceased alive on June 21, 1960, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Glover, Md — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 23, 1960

22c. PHYSICIAN'S NAME (Type): VICTOR L. GLOVER, M.D.

22d. ADDRESS: 407 West King St Martinsburg, W. Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-23-1960

23c. NAME OF CEMETERY OR CREMATORY: Rosedale Cemetery

23d. LOCATION (City, town, or county) (State): Martinsburg, West Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Howard K. Brown — ADDRESS: Martinsburg, W. Va.

25a. REC'D BY REGISTRAR DATE: JUN 27 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7402

07402

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 12 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BRETHEDSVILLE RURAL
d. STREET ADDRESS: BOONSBORO MD. R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALVEY Middle LEE Last MAYHUGH

4. DATE OF DEATH: Month JUNE Day 24 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY-2-1896
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months 1 Days 22
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MACHINIST
10b. KIND OF BUSINESS OR INDUSTRY: VICTOR PRODUCTS CORP
11. BIRTHPLACE (State or foreign country): BOONSBORO WASH. Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HARRY MAYHUGH
14. MOTHER'S MAIDEN NAME: AMANDA HOOVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-18-1026
17. INFORMANT: MRS. EDNA MAYHUGH Address: BOONSBORO MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Papillary Carcinoma Bladder — INTERVAL BETWEEN ONSET AND DEATH: 1 Mo
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)
181.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/13/60 19 to 6/24/60 19 that (I) (we) last saw the deceased alive on 6/24/60 19, and that death occurred at 7 PM, from the causes and on the date stated above.

22a. SIGNATURE: Ralph F. Young M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/24/60
22c. PHYSICIAN'S NAME (Type): RALPH F. YOUNG
22d. ADDRESS: WILLIAMSPORT MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JUNE 27 1960
23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY
23d. LOCATION (City, town, or county) (State): HAGERSTOWN WASH. Co. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John A. Bard ADDRESS: BOONSBORO MD.
25a. REC'D BY REGISTRAR DATE JUN 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Item 20 Film 264 6-13-60 ams

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7403 — Reg. Dist. No. 07403

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md.
c. LENGTH OF STAY IN 1b: D. O. A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital D.O.A

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey — b. COUNTY: Gloucester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westville
d. STREET ADDRESS: 803 Broadway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

67X-3

3. NAME OF DECEASED (Type or print): First: Douglas — Middle: Gary — Last: Merriell

4. DATE OF DEATH: Month: June — Day: 6 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 27 1960

9. AGE (In years last birthday): ___ yrs. — IF UNDER 1 YEAR: Months 3 Days 11 — IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Woodbury N. J.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Wallace Merriell

14. MOTHER'S MAIDEN NAME: Joan Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Wallace Merriell — Address: 803 Broadway Westville N. J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffocation — INTERVAL BETWEEN ONSET AND DEATH: 10 min

924.0

DUE TO (b): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Placed in crib - face down - face became entangled in plastic bag at bottom of carriage

20c. TIME OF INJURY: Hour 11:15 a.m. p.m. — Month, Day, Year: 6 6 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) nr. Williamsport (County) Wash (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward W. Ditto III, M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward W. Ditto III, Pet

DATE SIGNED: 6/6/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 9-60

22c. NAME OF CEMETERY OR CREMATORY: Eglinton Cemetery

22d. LOCATION (City, town, or county) (State): Clarksboro N. J.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leaf — ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: JUN 9 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07404

7404

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 22 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 413 George Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 413 George Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN; Middle CHALICE; Last MILLER

4. DATE OF DEATH: Month June; Day 26; Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: August 16, 1895

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cooks Helper

10b. KIND OF BUSINESS OR INDUSTRY: Restraunt

11. BIRTHPLACE (State or foreign country): Franklin Co., Penn.½

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Miller

14. MOTHER'S MAIDEN NAME: Linnie Holsinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 188-09-5447H

17. INFORMANT: Mrs. Virgie Daley — Address: Shady Grove, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure due to — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

420.0

DUE TO
(b): Arteriosclerotic Heart Disease. — Years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial Asthma and Emphysema.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1960 to June 26, 1960 that (I) (we) last saw the deceased alive on 6-26-1960, and that death occurred at 8P M, from the causes and on the date stated above.

22a. SIGNATURE: R. A. Bell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 28, 1960

22c. PHYSICIAN'S NAME (Type): R. A. Bell, M. D.

22d. ADDRESS: Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/29/1960
23c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
23d. LOCATION (City, town, or county) (State): Waynesboro, Pennsylvania

24. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: JUN 29 '60
25b. REGISTRAR'S SIGNATURE: Clarissa S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7405 — 07405 — Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: NEW YORK — b. COUNTY: ONONDAGA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYRACUSE — 69X-3
d. STREET ADDRESS: 532 NORTH SALINA STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANTOINETTE — Middle — Last NASTRI
4. DATE OF DEATH: Month JUNE — Day 16 — Year 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCT 16 1884
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TAILORING
10b. KIND OF BUSINESS OR INDUSTRY: SUIT MANUFACTORS
11. BIRTHPLACE (State or foreign country): ITALY — ABOLI PROV. OF NAPLES
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ? DiMASI
14. MOTHER'S MAIDEN NAME: ELIZABETH ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: EDMUND NASTRI 244 HARDING ST SYRACUSE N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Subdural and — INTERVAL BETWEEN ONSET AND DEATH: about
DUE TO (b): Subarachnoid Hemorrhage — 44m
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ① multiple body contusions ② multiple fractured ribs
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): was thrown from auto in Accident.
20c. TIME OF INJURY — Hour: 8 a. m. p. m. — Month, Day, Year: 6 14 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) (County) (State): Mt. Fredorick, Fred. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Edward W. Ditto III, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 6/17/60
EXAMINER'S NAME (Type): E W DITTO III

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 6/17/60
22c. NAME OF CEMETERY OR CREMATORY: ASSUMPTION CEMETERY
22d. LOCATION (City, town, or county) (State): SYRACUSE NEW YORK

23. SIGNATURE OF FUNERAL DIRECTOR: Charles M Rouzer — NAME OF FUNERAL HOME: ROUZER FUNERAL HOME — ADDRESS: HAGERSTOWN MARYLAND
24a. REC'D BY REGISTRAR — DATE: JUN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7444

07406

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAPLAND RURAL
c. LENGTH OF STAY IN 1b: 38 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GAPLAND MD.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GAPLAND RURAL
d. STREET ADDRESS: GAPLAND MD.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First CLARENCE Middle EDWARD Last NORRIS

4. **DATE OF DEATH**: Month JUNE Day 20 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: MARCH. 20. 1889

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months 3 Days 0
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (State or foreign country): TREGO WASH. CO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE E. NORRIS

14. MOTHER'S MAIDEN NAME: MARY ELLEN GLOSS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-30-9374

17. **INFORMANT** Address: MRS. NANNIE NORRIS - GAPLAND MD.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO
(b):
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 10 1960 to June 20 1960, that (I) (we) last saw the deceased alive on June 17 1960, and that death occurred at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: G. W. LeVan M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): G. W. LeVan

22d. ADDRESS: Boonsboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JUNE. 24. 1960

23c. NAME OF CEMETERY OR CREMATORY: PLESANT VIEW CEMETERY

23d. LOCATION (City, town, or county) (State): BURKETTSVILLE FRED. CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John A. East

ADDRESS: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE: JUN 22 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7406

Reg. Dist. No. 07407

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 12 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ~~411 MITCHELL AVE.~~ WASHINGTON CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
d. STREET ADDRESS 411 MITCHELL AV E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ALICE Middle VIRGINIA Last OREN

4. DATE OF DEATH Month JUNE Day 25 Year 19 60

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 2/27/1873
9. AGE (In years lost birthday) 87 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JEREMIAH STILL
14. MOTHER'S MAIDEN NAME MARY McCORMICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
INFORMANT MR. JERRY M. OREN Address PERTH AMBOY N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis Gen
DUE TO (b) Cardiovascular Disease
DUE TO (c) Myocardial Enlargement

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH
(a) yrs
(b) mos
(c) yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Hernia Fem - Obstruction Small Bowel

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 55 to June 25, 1960, that I last saw the deceased alive on June 24, 1960, and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE Louis G. Gratz M.D.
ADDRESS (Street, city or town, state) 119 E. Antietam Hagerstown
DATE SIGNED 6/29/60
PHYSICIAN'S NAME (Type) Louis G. Gratz

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 6/29/60
22c. NAME OF CEMETERY OR CREMATORY THREE CHURCH HILL CEM.
22d. LOCATION (City, town, or county) MATINS CREEK (State) PENNA.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. J. Norment, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE JUN 28 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7407

Reg. Dist. No. 07408

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: ELEVEN YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1004 SALEM AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 1004 SALEM AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALDINE Middle D Last PALMER

4. DATE OF DEATH: Month JUNE Day 18 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY-17-1902

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months 1 Days 1
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINE OPERATOR - HAGERSTOWN SHOE CO.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): NEAR MYERSVILLE FRED. CO

12. CITIZEN OF WHAT COUNTRY? MD. U.S.A.

13. FATHER'S NAME: EDWARD PALMER

14. MOTHER'S MAIDEN NAME: SARAH E. KOOGLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-5783

17. INFORMANT: MRS. NAOMI PALMER Address: 1004 SALEM AVE. HAGERSTOWN MD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound Head — INTERVAL BETWEEN ONSET AND DEATH: Immed.
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): (1) Diabetes Mellitus (2) Hypertension (3) Depressive Reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self Inflicted wound Rt. temporal Area

20c. TIME OF INJURY: Hour 4:20 o. m. p. m. Month, Day, Year: 6 20 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Hagerstown (County) Wash (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward W. Ditto III M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 6/20/60

EXAMINER'S NAME (Type): Edward W. Ditto III, M. D. Acty

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JUNE 21 1960
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY
22d. LOCATION (City, town, or county) (State): HAGERSTOWN WASH. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Bast
ADDRESS: BOONSBORO MD.
24a. REC'D BY REGISTRAR DATE: JUN 22 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7408

## CERTIFICATE OF DEATH

07409

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 30 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY WASH.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
d. STREET ADDRESS 38 N. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HELEN Middle I. Last PHELPS

4. DATE OF DEATH Month 6 Day 24 Year 19 60

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH MAY 30, 1905

9. AGE (In years last birthday) 55 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK

10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME EDWARD J. HEEFNER

14. MOTHER'S MAIDEN NAME ANNIE M. ODEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 161-12-0444

17. INFORMANT Address MRS. MARY GEIST III 4 S. POTOMAC ST. HAGERSTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lungs — INTERVAL BETWEEN ONSET AND DEATH: 2 MO.

DUE TO (b) Adenocarcinoma of Breast, Rt. — 14 YR +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) ___

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 9, 1959 to June 24 1960 that (I) (we) last saw the deceased alive on June 23 1960, and that death occurred at 3:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE Richard V. Hauver M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED June 24, 60

22c. PHYSICIAN'S NAME (Type) Richard V. HAUVER

22d. ADDRESS 247 N. Potomac St. Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE THEREOF 6/27/1960

23c. NAME OF CEMETERY OR CREMATORY ROSE HILL

23d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FRED W. KRAISS HAGERSTOWN, MD.

25a. REC'D BY REGISTRAR DATE JUN 27 '60

25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7409

## CERTIFICATE OF DEATH

07410

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Sharpsburg
d. STREET ADDRESS: Sharpsburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ada; Middle: Colbert; Last: Poffenberger

4. DATE OF DEATH: Month: June; Day: 28; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 11 1888

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: 3; Days: 16
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Knotts Quarry W. Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Benjamin Colbert

14. MOTHER'S MAIDEN NAME: Anna Grey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give wor or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Thomas R. Poffenberger — Address: Sharpsburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction left Kidney — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Thrombosis left Renal Artery — 7 days
DUE TO (c): Atherosclerosis

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost.

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility -

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 20 June 1960 to 27 June 1960 that (I) (we) last saw the deceased alive on 27 June 1960 and that death occurred at 3P M, from the causes and on the date stated above.

22a. SIGNATURE: Frank E Brumback M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Frank E Brumback
22d. ADDRESS: 170 west washington St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 1-60
23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
23d. LOCATION (City, town, or county) (State): Sharpsburg Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: Williamsport Md

25a. REC'D BY REGISTRAR DATE: JUL 5 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7410

07411

1 PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 25 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MD. STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 03
d. STREET ADDRESS 214 SUMMIT AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Millard Middle Guy Last Poole
4. DATE OF DEATH Month 6 Day 14 Year 1960
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8/12/1895
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY SERVICE STATION
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ABRAHAM L. POOLE
14. MOTHER'S MAIDEN NAME MAMIE TOMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-09-7137
17. INFORMANT MR. ROY POOLE Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH 24 hours
DUE TO (b) Hypernephroma with generalized Carcinomatosis — 10 Months
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

180X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 8, 1960 to June 14, 1960, that (I) (we) last saw the deceased alive on June 14, 1960 and that death occurred at 4:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE Young E. Chun M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Dr. Young E. Chun
22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 6/16/60
23c. NAME OF CEMETERY OR CREMATORY REFORMED CHURCH CEM.
23d. LOCATION (City, town, or county) (State) MIDDLETOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE W. T. Norment ADDRESS Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE JUN 16 '60
25b. REGISTRAR'S SIGNATURE Cletus E. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7411

07412

1

M

DR. HIRSHMAN 159-W. WASH. ST. HAG.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 12 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. BRIER - RURAL
d. STREET ADDRESS: ~~Boonsboro~~ KEEDYSVILLE MD R.1.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle T Last REESE

4. DATE OF DEATH: Month JUNE Day 28 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 28 - 1876

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months 10 Days 0 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SCHOOL TEACHER

10b. KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOLS

11. BIRTHPLACE (State or foreign country): MT. LEBA WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: EZRA REESE

14. MOTHER'S MAIDEN NAME: MARTHA ARNOLD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-20-8249

17. INFORMANT: MRS. ELSIE M. REESE Address: KEEDYSVILLE MD R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Coronary Occlusion | 1 day |
| DUE TO (b) | Arteriosclerotic Heart Disease | 5 yrs. |
| DUE TO (c) | Arteriosclerosis | 5 yrs. |

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 7 1955 to June 28 1960, that (I) (we) last saw the deceased alive on June 27 1960, and that death occurred at 7:25 M, from the causes and on the date stated above.

22a. SIGNATURE: Philip J. Hirshman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/28/60

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22d. ADDRESS: 159 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JULY-1-1960

23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY

23d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John W. Bast ADDRESS: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE: JUL 5 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7412 07413

## CERTIFICATE OF DEATH

302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R#3
d. STREET ADDRESS: Funkstown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ELLSWORTH Middle ROHRBACK Last ROULETTE

4. DATE OF DEATH: Month June Day 16, Year 1960 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26, 1890

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): President, Nicodemus Bank

10b. KIND OF BUSINESS OR INDUSTRY: Bank

11. BIRTHPLACE (State or foreign country): Sharpsburg Wash Co Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Roulette

14. MOTHER'S MAIDEN NAME: Annie Rohrback

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 219-30-3818

17. INFORMANT — Address: Robert E. Roulette, Hagerstown R#3 Md

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 hours.
DUE TO
(b): Atherosclerosis — Years.
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 16, 1960, to June 16, 1960, that (I) (we) last saw the deceased alive on June 16, 1960, and that death occurred at 6A M, from the causes and on the date stated above.

22a. SIGNATURE: R. A. Bell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 18, 1960

22c. PHYSICIAN'S NAME (Type): R. A. Bell, M.D.

22d. ADDRESS: Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/18/60

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Andrew K. Coffman, Hagerstown, Md

25a. REC'D BY REGISTRAR DATE: JUN 20 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7413

## CERTIFICATE OF DEATH

07414

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN MD.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WESTERN MD. STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
d. STREET ADDRESS: 1 LAKIN AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Elizabeth Last: Russler

4. DATE OF DEATH: Month: June Day: 28 Year: 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY-36-1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: 10 Days: 28
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): BOONSBORO WASH. Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: SAMUEL MEREDITH
14. MOTHER'S MAIDEN NAME: FANNIE FLOOK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHN T. RUSSLER Address: BOONSBORO MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobular pneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): carcinomatosis — unknown
DUE TO
(c): carcinoma of the breast — 8 yrs.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Nat while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 21 1960, to June 28 1960, that (I) (we) last saw the deceased alive on June 28 1960, and that death occurred at 5:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: June 28, 1960
22c. PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, M.D.
22d. ADDRESS: Western Md. State Hospital, Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JUNE 30 1960
23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
23d. LOCATION (City, town, or county) (State): BOONSBORO WASH. Co. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John D. Bast ADDRESS: BOONSBORO MD.
25a. REC'D BY REGISTRAR DATE: JUL 5 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Thrush

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

1

Item 20 Film 265 6-28-60 ams

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7420

07415
Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

**1. PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): rear of 615 Elizabeth Ave.

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Williamsport
d. STREET ADDRESS: Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Richard — Middle: --- — Last: St. Clair

**4. DATE OF DEATH**: Month: June — Day: 19 — Year: 1960

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Sept. 27, 1926

**9. AGE** (In years last birthday): 33 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Crator

**10b. KIND OF BUSINESS OR INDUSTRY**: Furniture

**11. BIRTHPLACE** (State or foreign country): Hagerstown Md.

**12. CITIZEN OF WHAT COUNTRY?**:

**13. FATHER'S NAME**: Oscar St. Clair

**14. MOTHER'S MAIDEN NAME**: Ruth Cave

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W.II

**16. SOCIAL SECURITY NO.**: 220-18-3288

**17. INFORMANT** — Address: Mrs. Ruth V. St. Clair Williamsport Tr. 2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration vomitus
DUE TO (b): Acute alcoholic intoxication
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: unknown

921.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.): Ac. Alcohol intoxication - lay on back seat of car - vomited and aspirated vomitus

**20c. TIME OF INJURY**: Hour: unknown a.m. p.m. — Month, Day, Year: 6 19 1960

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): St.

**20f.** (City or town): Hagerstown (County): Wash (State): Md.

**21.** I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Edward W Ditto III M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward W. Ditto III

DATE SIGNED: 6/20/60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**22b. DATE THEREOF**: 6-21-60
**22c. NAME OF CEMETERY OR CREMATORY**: Cedar Lawn
**22d. LOCATION** (City, town, or county) (State): Hagerstown Md.

**23. FUNERAL DIRECTOR'S SIGNATURE**: Scott F. Minnich & Son
ADDRESS: Hagerstown Md.

**24a. REC'D BY REGISTRAR** DATE: JUN 22 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Frank

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7414

# CERTIFICATE OF DEATH

07416
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro 75x-3
d. STREET ADDRESS: 306 West Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence — Middle: R — Last: Schaeffer

4. DATE OF DEATH: Month: June — Day: 10 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 12, 1886

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner

10b. KIND OF BUSINESS OR INDUSTRY: Confectionery Store

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob W. Schaeffer

14. MOTHER'S MAIDEN NAME: Sarah Reeder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 186-28-2737

17. INFORMANT: Mrs. Neadia P. Schaeffer, 306 W. Main St. — Address: Waynesboro, Pa.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Reticulum cell sarcoma, retroperitoneal — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.
200.0
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. / p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1940, to June 10, 1960, that I last saw the deceased alive on June 10, 1960, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Brewer M.D.
ADDRESS (Street, city or town, state): 359 E. Baltimore St.
DATE SIGNED: 6/11/60

PHYSICIAN'S NAME (Type): W. C. Brewer, M. D. — Greencastle, Penna.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 13, 1960
22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
22d. LOCATION (City, town, or county) (State): Waynesboro, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: S. Marlin Roe
ADDRESS: Waynesboro, Penna.

24a. REC'D BY REGISTRAR DATE: JUN 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7415 — Reg. Dist. No. 07417

1. PLACE OF DEATH
a. COUNTY WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 40 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
d. STREET ADDRESS 276 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First SAMUEL Middle MONROE Last SHAFFER
4. DATE OF DEATH Month JUNE Day 6 Year 19 60
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12/21/1891
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PLUMBER
10b. KIND OF BUSINESS OR INDUSTRY PLUMBING REPAIR CO.
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIAM H. H. SHAFFER
14. MOTHER'S MAIDEN NAME PHIANNA RHODES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-09-2794A
17. INFORMANT MRS. DOROTHY SHAFFER Address HAGERSTOWN MD.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 days
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease — 10 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 2, 19 60 to June 6, 19 60, that I last saw the deceased alive on June 5, 19 60, and that death occurred at 12:45 am. M, from the causes and on the date stated above.

ACTUAL SIGNATURE W. T. Layman, M.D. — ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. — DATE SIGNED 6/8/60

PHYSICIAN'S NAME (Type) W. T. Layman, M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) 6/8/60
22b. DATE THEREOF BURIAL
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE W. T. Forrest, Hagerstown, Md. — ADDRESS
24a. REC'D BY REGISTRAR DATE JUN 10 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Krantz

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7416 07418

## CERTIFICATE OF DEATH

M

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 8 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown (Rural)
d. STREET ADDRESS: RFD #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Debra; Middle: Lee; Last: Shank

4. DATE OF DEATH: Month: June; Day: 1; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 1 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours: 8; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dale Lee Shank

14. MOTHER'S MAIDEN NAME: Betty Maugans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mr. Dale Lee Shank Hagerstown Md RFD #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 Hrs.

325.4

DUE TO (b): Mongolism & congenital defects — "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): of heart

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 6-1 1960 to 6-1 1960, that (I) ~~(we)~~ last saw the deceased alive on 6-1 1960, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Hess M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Charles F. Hess M.D.

22d. ADDRESS: Smithsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 3-60

23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

23d. LOCATION (City, town, or county) (State): Williamsport Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leif

ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE: JUN 6 '60

25b. REGISTRAR'S SIGNATURE: Curtis L. Evans

2081 81 XV 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7417 — 07419

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 664 OAK RIDGE DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle — Last SHANTZ
4. DATE OF DEATH: Month JUNE — Day 6 — Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 12 1896
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FREIGHT CONDUCTOR
10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: GEORGE SHANTZ
14. MOTHER'S MAIDEN NAME: BESSIE LINEBAUGH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 719-05-6263
17. INFORMANT — Address: HARRY Y SHANTZ RT #4 HAGERSTOWN MARYLAND

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
002X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Aneurisim of Abdominal Aorta. Hypertrophy of Prostate — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-2 1958 to June 6 1960, that (I) (we) last saw the deceased alive on 6-5 1960, and that death occurred at 8:34 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert P. Conrad M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 6-6-60
22c. PHYSICIAN'S NAME (Type): ROBERT P CONRAD M.D.
22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 6/8/60 — 23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY — 23d. LOCATION (City, town, or county) (State): HAGERSTOWN MARYLAND

24. SIGNATURE OF FUNERAL DIRECTOR: SUPER-ROUZER FUNERAL HOME Charles M Rouzer — ADDRESS: HAGERSTOWN MD.
25a. REC'D BY REGISTRAR DATE: JUN 8 '60 — 25b. REGISTRAR'S SIGNATURE: Clinton L. Kraus

VR A15 (4) 15M 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07420

1. PLACE OF DEATH — a. COUNTY: Washington 7445 — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural 2 Hancock Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural 2 Hancock Maryland
d. STREET ADDRESS: Rural 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Middle Last: Thornton John Shoemaker
4. DATE OF DEATH: Month 6 Day 1 Year 19 60

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4.8.1883
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: Labor
11. BIRTHPLACE (State or foreign country): Washington County Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Shoemaker
14. MOTHER'S MAIDEN NAME: Catherine McCarty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-09-9446
17. INFORMANT — Address: Mrs Leathia Shoemaker Rural 2 Hancock Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 da
DUE TO (b): Carcinoma Stomach — 14 Mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Senile
151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/25 1960 to 6/1 1960 that (I) (we) last saw the deceased alive on 6/1 1960 and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: L M Shaffer M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): L M SHAFFER
22d. ADDRESS: Hancock, md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6.4.60
23c. NAME OF CEMETERY OR CREMATORY: Stone Bridge Brethern
23d. LOCATION (City, town, or county) (State): Rural Hancock Washington Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Howard J Shoemaker Hancock Md
25a. REC'D BY REGISTRAR — DATE: JUN 7 '60
25b. REGISTRAR'S SIGNATURE: Clifford L. Keiser

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7427 07421

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: REEDER NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 113 JOHN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARLAN Middle WINFIELD Last SMITH

4. DATE OF DEATH: Month JUNE Day 12 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL-8-1880

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months 2 Days 4 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED POLICEMAN HAGERSTOWN CITY PARK
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BOONSBORO WASH. CO. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: OTHO SMITH
14. MOTHER'S MAIDEN NAME: FLORENCE HORINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-18-2146
17. INFORMANT: HERBERT W. SMITH Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 2 1960 to June 12 1960 that (I) (we) last saw the deceased alive on June 12 1960 and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: J Secondari M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 13. 60

22c. PHYSICIAN'S NAME (Type): JOSEPH SECONDARI
22d. ADDRESS: BOONSBORO MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JUNE. 15. 1960
23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
23d. LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John A. Bast
ADDRESS: BOONSBORO MD.
25a. REC'D BY REGISTRAR DATE: JUN 17 '60
25b. REGISTRAR'S SIGNATURE: Clifton L Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. SECONDARI

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07422

## CERTIFICATE OF DEATH

7418 Item 8 #11W6264 6-8-60 et

1. PLACE OF DEATH
a. COUNTY: Washington
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washingtonn County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 143 W. Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle JULIA Last SOCKS

4. DATE OF DEATH: Month June Day 1 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 26 1914 1917
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: WILLIAM DIDDLEBOCK
14. MOTHER'S MAIDEN NAME: MARY SOCKS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Robert H Socks Address: Cumberland Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO
(b): Coronary atherosclerosis — Unknown
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Postoperative atelectasis and pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-15-60 19___ to 6-1-60 19___, that (I) (we) last saw the deceased alive on 5-31-60 19___, and that death occurred at 2:15 A M, from the causes and on the date stated above.

22a. SIGNATURE: Paul Harrison M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-3-60
22c. PHYSICIAN'S NAME (Type): Paul Harrison M D
22d. ADDRESS: 318 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/4/60
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Maryland

24. SIGNATURE OF FUNERAL DIRECTOR: Charles M Rowser
ADDRESS: Hagerstown Maryland

25a. REC'D BY REGISTRAR DATE: JUN 6 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper covers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7419 **CERTIFICATE OF DEATH** 302 07423

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 Mi.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 88 West Lee St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 3100 Hillandale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle WILSON Last SOUTH

4. DATE OF DEATH: Month June Day 7 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 16 1918

9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Tavern Operator

11. BIRTHPLACE (State or foreign country): Md. Funkstown Wash Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roy O. South

14. MOTHER'S MAIDEN NAME: Naomi Knott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.# 2

16. SOCIAL SECURITY NO.: 220-05-6109

17. INFORMANT: Mrs Dorothy South 3100 Hillandale Rd Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes

420 x1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): 
DUE TO (c): 

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 19, 1957 to June 7, 1960 that (I) (we) last saw the deceased alive on June 6, 1960, and that death occurred at 8:15 P.m. from the causes and on the date stated above.

22a. SIGNATURE: R. A. Bell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 9, 1960.

22c. PHYSICIAN'S NAME (Type): R. A. Bell, M.D.

22d. ADDRESS: Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/10/60

23c. NAME OF CEMETERY OR CREMATORY: Rest Havnen Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUN 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7421

07424

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Route#4 X
d. STREET ADDRESS: Cearfoss 1
e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print): First Jacob — Middle Roman — Last Stockslager

4. DATE OF DEATH: Month June — Day 23 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feby 21 1882

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Hagerstown Wash ¾ Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob R. Stockslager

14. MOTHER'S MAIDEN NAME: Mary Eliz Winter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Raymond W. Stockslager Address: Hagerstown Md R # 4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

420.0

DUE TO (b): Nephrosclerosis + Prostatic obst. — Chronic,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerotic Heart Disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 25 July 19 51 to 23 June 1960, that (I) (we) last saw the deceased alive on 23 June 1960, and that death occurred at 9:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard T. Binford M.D.

ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 24 JUNE 60

22c. PHYSICIAN'S NAME (Type): RICHARD T. BINFORD, M. D.

22d. ADDRESS: 1135 POTOMAC AVENUE, HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/26/60

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Wash & Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUN 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07425

Reg. Dist. No.

7446

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural 2 Hancock Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Little Pool Near Hancock Md.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural 1 Hancock Maryland
d. STREET ADDRESS: Rural 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Seibert — Last: Stotler

4. DATE OF DEATH: Month: 6 — Day: 5 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4.23.1916

9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: House Painting

11. BIRTHPLACE (State or foreign country): Morgan County W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence Stotler

14. MOTHER'S MAIDEN NAME: Irene Waugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War 2

16. SOCIAL SECURITY NO.: 232-26-6304

17. INFORMANT: Mary F Stotler — Address: Rural 1 Hancock Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 850X ARTERIOSCLEROSIS
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Either slipped or fell from roof in Little Pool (Canal)

20c. TIME OF INJURY: Hour: 3:30 p. m. — Month, Day, Year: 6-5-1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Canal

20f. (City or town): Hancock — (County): Washington — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W E Witt Jr

DATE SIGNED: 6/6/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6.8.60
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or county) (State): Morgan County W.VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F Stone — ADDRESS: Hancock Md

24a. REC'D BY REGISTRAR DATE: JUN 9 '60

24b. REGISTRAR'S SIGNATURE: Charles S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

7447

07426 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro
c. LENGTH OF STAY IN 1b years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Boonsboro
d. STREET ADDRESS Route 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Albert Middle C. Last Stottlemyer
4. DATE OF DEATH Month 6 Day 14 Year 1960

5. SEX male
6. COLOR OR RACE white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 10/24/1881
9. AGE (In years last birthday) 78 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner
10b. KIND OF BUSINESS OR INDUSTRY farm
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Hamilton Stottlemyer
14. MOTHER'S MAIDEN NAME Susanna Hoover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
INFORMANT Address Mrs. Mary Stottlemyer, Boonsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorraghe — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Sanguine of both Lower Legs — 10 Days
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO (c) Generalized arteriosclerosis.
331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 15, 1950, to June 14, 1960 that I last saw the deceased alive an June 14, 1960, and that death accurred at 1 30P M, fram the causes and an the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE J Secondari M.D.
PHYSICIAN'S NAME (Type) JOSEPH SECONDARI Boonsboro MD

22a. BURIAL, CREMATION, REMOVAL (Specify) burial
22b. DATE THEREOF 6/16/1960
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery
22d. LOCATION (City, town, or county) Middletown, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, ADDRESS Middletown, Md.
24a. REC'D BY REGISTRAR DATE JUN 20 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Item 20 Film 266 6 15 60 [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7422 07427

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 1WEEK
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE NEW YORK b. COUNTY SUFFOLK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST ISLIP LONG ISLAND
d. STREET ADDRESS 163 MALTS AVE. 69X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First TINA Middle LEE Last TRUMPOWER
4. DATE OF DEATH Month JUNE Day 8 Year 1960
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9/4/1957
9. AGE (In years last birthday) 2 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME LLOYD KENNETH TRUMPOWER
14. MOTHER'S MAIDEN NAME SHIRLEY BRINING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT MRS. EDITH TRUMPOWER Address HAGERSTOWN MD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extradural hematoma due — INTERVAL BETWEEN ONSET AND DEATH 8 days

DUE TO (b) to fracture Rt & parietal bone &

DUE TO (c) severed middle meningeal Artery

902.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Playing in yard with grandfather - fell from his arm and struck head on ground

20c. TIME OF INJURY Hour 4 -- p.m. Month, Day, Year 6 6 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) About Home
20f. (City or town) Hagerstown (County) Wash (State) Md

21. I certify that I taak charge of the remains described abave, held an Autopsy ☐, Inspectian ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Edward W. Ditto III M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED 6/8/60

EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 6/9/60
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.
22d. LOCATION (City, town, or county) HAGERSTOWN (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS W. J. Norment Hagerstown, Md
24a. REC'D BY REGISTRAR DATE JUN 10 '60
24b. REGISTRAR'S SIGNATURE C. Kent S. Knode

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar priar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7423 — 07428

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md
c. LENGTH OF STAY IN 1b: 6 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural 2 Hancock
d. STREET ADDRESS: / Rural 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pamela — Middle: Dianne — Last: Weller

4. DATE OF DEATH: Month: 6 — Day: 14 — Year: 19 60

5. SEX: ~~M~~ Female

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6.6.1960

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months — Days: 6 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Howard J Weller Jr.

14. MOTHER'S MAIDEN NAME: Henrietta M Hose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Howard J Weller Jr Rural 2 Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Intestinal Ilius — 2d
DUE TO
(c):

570 N

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Immaturity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6 June 1960, to 14 June 1960, that (I) (we) last saw the deceased alive on 14 June 1960, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Harold H Gist M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): HAROLD H-GIST M-D.

22d. ADDRESS: 111 N. Potomac St. MD - HAGERSTOWN

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6.15.60

23c. NAME OF CEMETERY OR CREMATORY: Orchard Ridge

23d. LOCATION (City, town, or county) (State): Rural Hancock Washington Md

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Howard P Gore Hancock Md

25a. RECD BY REGISTRAR DATE: JUN 20 60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2081348XVO

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7424 — Reg. Dist. No. 07429

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 19 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital
d. STREET ADDRESS: 1412 Oak Hill Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John Middle: Kenneth Last: Wheeler, Sr.
4. DATE OF DEATH: Month: June Day: 15, Year: 1960

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 24, 1901
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ex. Vice Pres.
10b. KIND OF BUSINESS OR INDUSTRY: refrigeration Mfg.
11. BIRTHPLACE (State or foreign country): Berwick, Penna.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry C. Wheeler
14. MOTHER'S MAIDEN NAME: Vernie Kingsbury

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 226-09-8024
INFORMANT: Wilba Wheeler, Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.
DUE TO (b): Hypertensive Cardio Vascular Disease (Treated Hypertyme) — 4 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 6-14, 1960, to 6-15-60, 1960, that I last saw the deceased alive on 6-15, 1960, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert P. Conrad M.D. — ADDRESS (Street, city or town, state): 137 W. Washington — DATE SIGNED: 6-15-60
PHYSICIAN'S NAME (Type): Robert P. Conrad, MD — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6-18-60
22c. NAME OF CEMETERY OR CREMATORY: Pine Grove Cemetery
22d. LOCATION (City, town, or county) (State): Berwick, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: JUN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07430

7425 Item 14 #1M4266 7-6-60 et

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Md. State Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminister 0627.2
d. STREET ADDRESS: Alms House
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: James — Middle: Henry — Last: WHITE

**4. DATE OF DEATH**: Month: 6 — Day: 20 — Year: 1960

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

**8. DATE OF BIRTH**: Sept. 2, 1892

**9. AGE** (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

**10b. KIND OF BUSINESS OR INDUSTRY**

**11. BIRTHPLACE** (State or foreign country): Md.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Albert White

**14. MOTHER'S MAIDEN NAME**: Ellen Becraft

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): Unknown
(If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT**: Hospital record — Address

### MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration of blood — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes
DUE TO (b): Carcinoma of the tongue — 1 year
DUE TO (c):

141.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☑ NO ☐

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

**20d.** INJURY OCCURRED While at work ☐ Not while at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21.** I certify that (I) (this hospital) attended the deceased from March 16, 1960 to June 20, 1960 that (I) (we) last saw the deceased alive on June 20 1960, and that death occurred at 3:45 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Young E. Chun — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

**22b. DATE SIGNED**: June 21, 1960

**22c. PHYSICIAN'S NAME** (Type): YOUNG E. CHUN

**22d. ADDRESS**: 1500 Penna Ave. Hagerstown, Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Removal

**23b. DATE THEREOF**: 6-22-60

**23c. NAME OF CEMETERY OR CREMATORY**: Anatomy Bd. U. of Md.

**23d. LOCATION** (City, town, or county) (State): Baltimore Md.

**24. FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS

**25a. REC'D BY REGISTRAR** DATE: JUN 27 '60

**25b. REGISTRAR'S SIGNATURE**: Louise E. Triana

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the balance of papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7426 Reg. Dist. No. 07431

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg rural

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital
d. STREET ADDRESS: RFD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Icia Middle: Etta Last: Wolfe
4. DATE OF DEATH: Month: June Day: 15 Year: 19 60

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 5, 1889
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Garfield, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Roman Wolfe
14. MOTHER'S MAIDEN NAME: Laurah Kuhn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-18-1185
INFORMANT: Charles F. Wolfe, Address: Smithsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Agranulocytosis — INTERVAL BETWEEN ONSET AND DEATH: 3 Wks.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Probable Aspirin Toxicity

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/3, 1954, to 6/15, 1960 that I last saw the deceased alive on 6/15, 1960, and that death occurred at 9:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Hess M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 6/16/60

PHYSICIAN'S NAME (Type): Charles F. Hess M.D. — Smithsburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6-19-60
22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
22d. LOCATION (City, town, or county) (State): Smithsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.
24a. REC'D BY REGISTRAR DATE: JUN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB